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SYPHILIS IN RELATION TO THE ETIOLOGY AND DIAGNOSIS OF TUBERCULOSIS *

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SYPHILIS and tuberculosis have one very striking point in common, namely, the liability of the disease to break out again years after the original lesion has apparently healed. The two diseases may exist in the same patient, so that if late manifestations of disease occur it is sometimes difficult to decide whether they are due to syphilis or tuberculosis.

Syphilis of lung, though a rare disease, is not so uncommon as was formerly believed. It usually leads to a fibrous induration spreading from the roots of the lungs, and it is probable that many cases diagnosed as hilum tuberculosis or peribronchial phthisis are really cases of syphilis. It must be remembered that active tuberculosis may exist at the same time, and the diagnosis be confused by finding tubercle bacilli in the sputum. In such a case one can say definitely that there is pulmonary tuberculosis, but if the Wassermann reaction is positive, or there are signs of syphilis in other parts of the body, it is not possible to tell to what extent, if any, syphilis has invaded the lung tissue.

In arriving at a diagnosis the following points are important :—

(1) In chronic pulmonary tuberculosis tubercle bacilli are almost always present in the sputum. If repeated examinations of the sputum fail to show the presence of tubercle bacilli one should bear in mind the possibility of the disease being non-tuberculous, however much the signs may indicate tuberculosis.

(2) Signs of fibrosis at the roots of the lungs spreading towards the bases and associated with very few consti-

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tutional symptoms are not common in tuberculosis, but are consistent with syphilis.

(3) In tuberculosis there is often considerable disease without great dyspnoea, but in syphilis dyspnoea is the most prominent symptom. The patient's weight and general health are often very little affected, and the blood pressure tends to rise rather than to fall.

(4) A positive Wassermann reaction does not, of course, indicate that there is syphilis of the lung.

(5) Improvement on anti-syphilitic treatment confirms a diagnosis of syphilis.

There are, of course, other forms of syphilis in the lungs and mediastinum apart from peribronchial fibrosis. A mediastinal gumma may produce signs and symptoms which closely resemble those of a neoplasm.

A woman of thirty-four was admitted to hospital in April, 1922. She complained of dyspnoea which began in December, 1921, and became rapidly worse. There were signs of a large left pleural effusion, and I removed four pints of clear fluid, replacing it with oxygen. X-rays after this showed a mediastinal mass which was diagnosed as tumour. The fluid rapidly reaccumulated, and during her first month in hospital I removed sixteen pints. The fluid was sterile and pale yellow in colour and contained 86 per cent. small lymphocytes. After the first month the effusion reaccumulated less quickly, but a further ten pints were aspirated before she died in October, 1922. At the post-mortem examination the mediastinal tumour was found to be a gumma.

In another case I think the condition was syphilitic. The patient, a man of seventy-seven, was admitted to hospital in July with a six months' history of dyspnoea and cough. He had signs of pleural effusion and was aspirated, but the fluid rapidly reaccumulated, and after repeated aspirations he died in August. The fluid, which was clear to begin with, was blood-stained towards the end. It was sterile, and contained 83 per cent. small lymphocytes. He also had some ulceration on the tongue which I thought was epitheliomatous, especially in view of his age, but which was reported to be syphilitic. The Wassermann reaction was positive, and he was given anti-syphilitic treatment, but there were no signs of improvement, and he died a few weeks after admission.

In cases where syphilis and tuberculosis occur together

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it does not seem that the course of the tuberculosis is affected unfavourably, for the disease usually runs the course of the chronic fibroid type, nor is there sufficient evidence that syphilitic subjects are more likely to contract tuberculosis than others. The incidence of tuberculosis is not greater amongst children with congenital syphilis than it is amongst normal children.

In conclusion, I should say that clinically one sees two chief types of syphilis connected with the lungs: in one there is peribronchial fibrosis resembling chronic fibroid tuberculosis, in the other a mediastinal gumma producing effusion and resembling neoplasm.